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WIRED FOR HEALTH CARE QUALITY ACT

OCTOBER 1, 2007.—Ordered to be printed

Mr. KENNEDY, from the Committee on Health, Education, Labor, and Pensions, submitted the following

REPORT

[To accompany S. 1693]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 1693) to enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the costs of health care in the United States, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill (as amended) do pass.

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I. PURPOSE AND SUMMARY

The purpose of S. 1693, the "Wired for Health Care Quality Act" is to enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the cost of health care in the United States.

The bill amends the Public Health Service Act by adding a new title, "Health Information Technology and Quality". The bill enhances the use of health information technology to improve health care quality, while protecting the privacy and security of health in-

formation. The bill also establishes the Office of the National Coordinator for Health Information Technology within the Office of the Secretary for Health and Human Services (referred to hereafter as "the Secretary"), and formalizes the role of private entities in the standards-setting process by establishing the public-private Partnership for Health Care Improvement. The bill also establishes the American Health Information Community to provide advice to the Secretary and Federal agencies concerning policy considerations related to health information technology. The National Coordinator will serve as member of both the Partnership and the American Health Information Community, and will serve as a liaison between those entities and the Federal government. The bill authorizes three grant programs to facilitate the widespread adoption of interoperable health information technology. The legislation also authorizes competitive grants to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals. In order to improve health care quality, the bill tasks the Secretary with developing and utilizing quality measures and facilitates the analysis of large data sets to improve measurement of quality and efficiency of health care. Finally, the bill establishes a Health Information Technology Resource Center within the Agency for Health Care Research and Quality to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology.

II. Background and Need for Legislation

Studies by the Institute of Medicine and other expert bodies have revealed serious problems with health care quality and medical errors. Additionally, a RAND study stated that adult Americans receive recommended care only 55 percent of the time. Nearly 30 percent of health care spending is for treatments that may not improve health status, may be redundant, or may be inappropriate for the patient's condition according to Dartmouth University researchers.

Some of the most serious challenges facing health care today—medical errors, inconsistent quality, and rising costs—can be addressed through the effective application of health information technology linking all elements of the health care system and using the system to improve information available to physicians to improve quality, enhance preventive care, and reduce errors.

In April 2004, the President signed an Executive Order announcing his commitment to the promotion of health information technology to lower costs, reduce medical errors, improve quality of care, and provide better information for patients and physicians. In particular, the President called for widespread adoption of electronic health records and for health information to follow patients throughout their care in a seamless and secure manner.

This committee agrees that if we move from a paper-based health care system to secure, interoperable electronic health records, we will reduce mistakes and save lives, time and money. This legislation will bring the government and the private sector together to make health care better, safer and more efficient by accelerating

the widespread adoption of interoperable health information technology and quality measurement across our health care system.

Interoperability is a shared goal across the health care industry. The national strategy for achieving interoperability of digital health information calls for Federal agencies—who pay more than one-third of all health care costs—to collaborate with private entities in developing and adopting an architecture, standards, implementation specifications, a certification process, and a method of governance for ongoing implementation of health IT. Once the market has structure, patients, providers, medical professionals, and vendors will be better able to innovate, create efficiencies, and improve care.

The legislation formalizes involvement of private entities in the standards-setting process by establishing the Partnership for Health Care Improvement, composed of representatives of the public and private sectors. The National Coordinator for Health Information Technology will serve as a member of the Partnership.

The committee agrees that an investment in health information technology now will decrease health care costs over the long-term. This legislation targets Federal funding to those who need the most help updating and advancing health information technology.

III. Legislative History and Committee Action

The HELP Committee has a strong tradition of making bipartisan progress on health information technology, regardless of whether the chairmanship is held by a Republican or a Democrat.

In the 109th Congress, Senators Enzi, Kennedy, Frist, Clinton, Alexander, Dodd, Burr, Harkin, Isakson, Mikulski, DeWine, Jeffords, Roberts, Bingaman, Murray, Bond, Hagel, Martinez, Talent, Nelson (FL), and Obama introduced S. 1418, the "Wired for Health Care Quality Act." On July 20, 2005, the committee reported that bill (as amended by a Chairman's substitute) by unanimous voice vote. The bill was approved by the full Senate by unanimous consent on November 18, 2005. The House of Representatives also approved legislation on health information technology in the 109th Congress, but the Senate and House were unable to resolve the differences between the two bills before the 109th Congress adjourned.

The committee's commitment to health IT continued in the 110th Congress. On June 26, 2007, Senators Kennedy, Enzi, Clinton, Hatch, Obama, Alexander, Gregg, Isakson, Roberts, and Burr introduced S. 1693, the "Wired for Health Care Quality Act". On June 27, 2007, the committee held an executive session to consider S. 1693. After accepting a substitute amendment offered by Senator Kennedy and amendments offered by Senator Reed and Senator Dodd by unanimous voice vote, the committee approved S. 1693, as amended, by unanimous voice vote.

IV. Explanation of Bill and Committee Views

Office of the National Coordinator for Health Information Technology

In April 2004, by Executive Order, President George W. Bush established the Office of the National Coordinator for Health Information Technology, operating from the Office of the Secretary. The

Office is charged with developing a blueprint for a nationwide interoperable health information technology infrastructure and coordinating health information technology policies and programs across the Federal Government.

The National Coordinator will serve as member of both the Partnership and the American Health Information Community, serving as the primary advisor to the Secretary, and will serve as a liaison between those entities and the Federal Government, ensuring the adoption of standards for the electronic exchange of health information, and interacting with public and private stakeholders. In carrying out the activities of the Office, the National Coordinator shall work to ensure the security and privacy of patient health information and the electronic exchange of health information. Additionally, the Office of the National Coordinator shall be responsible for ensuring that health information technology initiatives are coordinated across programs of the Department of Health and Human Services as well as with other Federal agencies. The National Coordinator shall also review Federal health information technology investments to ensure investments are meeting published objectives and at the request of the Office of Management and Budget, shall provide advice and comments. The committee encourages the Office of the National Coordinator for Health Information Technology to work in collaboration with programs and departments within the Department of Health and Human Services, including the Office of Minority Health, Indian Health Service, Office for Civil Rights, Administration on Aging, and the Office of Disability, and with other Federal agencies including the Department of Justice. The committee encourages the National Coordinator to ensure that the membership of boards, councils, partnerships, working groups, and other entities created by and utilized by the Office are representative of the diversity of the Nation's populations and regions, and ensure a balance among various sectors of the health care system so that no single sector unduly influences the recommendations and outcomes. This is necessary to help ensure wider adoption and utilization of health information technology to improve health care quality and patient safety for all population groups, including populations at risk for health disparities, medically unserved and underserved populations, and rural populations.

The bill also specifies that an additional responsibility of the Office is to enhance the use of health information technology to improve the quality of health care in the prevention and treatment of chronic disease. The committee believes the United States cannot address rising health care costs without more focus on preventing chronic disease. According to the Centers for Disease Control, the medical care costs of people with chronic diseases account for more than 75 percent of the Nation's medical care costs. In addition, chronic disease accounts for 70 percent of all death in the United States. The committee believes adoption and promotion of health information technology can lead to innovative interventions to prevent disease and reduce health care costs. The committee encourages reports to assess the impact of health information technology in communities with health disparities and to identify practices to increase the adoption of such technology by health care providers in such communities.

The Secretary has begun undertaking the activities outlined in this section of the legislation. It is the committee's intent not to require the duplication of Federal efforts with respect to the establishment of the Office.

QUALIFIED HEALTH INFORMATION TECHNOLOGY

The committee believes that the inclusion of decision support in an interoperable health information technology system is critical to reducing medical errors and improving the quality of care patients receive. For that reason, the committee included the incorporation of decision support in the definition of qualified health information technology. The definition clearly states that qualified health information technology means a computerized system and it is the intent of the committee that decision support be included in that system, but the committee recognizes that each potential component (hardware or software) of a comprehensive interoperable health information technology system may not include a decision support feature. It is not the intention of the committee to restrict these components from participation in an interoperable qualified health information technology system, but rather to require that decision support be integrated within the system and available to any user.

The committee recognizes that there are a variety of policy and technical matters on which the recommendations and judgment of non-government experts are especially important. The technical challenges of implementing a nationwide health information architecture are formidable, and require careful consideration by those with special expertise in health care and information technology. To provide this important technical advice, the legislation establishes a private-sector Partnership for Health Care Improvement.

Equally important are the major social and policy considerations raised by broader use of health IT. These include questions of privacy and security, inclusion of all communities in the progress that health IT brings and the bridging of digital divides that might otherwise hinder the broader adoption of health IT. To provide advice to the Federal Government on these and similar important policy matters, the legislation establishes the American Health Information Community, the membership of which reflects the broad variety of perspectives needed to provide effective recommendations on policy challenges associated with health IT.

The areas of interest served by the Partnership and Community, though distinct, are clearly intertwined. For this reason, the legislation provides mechanisms to ensure that the deliberations of each body are informed by the other, and provides that the National Coordinator will liaise between the two.

PARTNERSHIP FOR HEALTH CARE IMPROVEMENT

The committee believes there are significant barriers to widespread adoption of interoperable health information technology. One of the primary barriers is the current lack of agreed-upon standards and common implementation guidelines and a certification process. The committee believes this bill addresses those factors in a way that appropriately incorporates involvement of both the public and private sectors.

The legislation establishes the Partnership for Health Care Improvement to recommend specific technical standards and policies

to achieve a nationwide interoperable health information technology infrastructure, and to serve as a forum for the participation of a broad range of stakeholders to provide input on achieving the interoperability of health information technology. It is the intent of the Committee to ensure that the Partnership recommends standards for the electronic exchange of health information and ongoing modifications to these standards facilitating the widespread adoption of interoperable health IT.

The Partnership shall strive for maximum cost-effectiveness by building on existing standards and policy work, establishing efficient processes and minimizing the negative economic impact of any new requirements it defines. As a general principle, the Partnership should seek existing solutions and minimal modifications, creating new solutions only when truly needed. Even so, some change will be required to ensure interoperability. The extent of such change must be determined using a defined process. To do so effectively requires close and continuous interaction with standards development organizations and other potential sources of relevant models for its own work.

The process to identify and specify these standards and policies must engage all affected stakeholders, as the credibility and compliance with the decisions of the Partnership will ultimately depend on whether those who are affected by standards and policies were able to participate in the decisionmaking process. It is the intent of the committee to ensure a balance among all stakeholders, so that no member organization unduly influences recommendations from the Partnership.

AMERICAN HEALTH INFORMATION COMMUNITY

The American Health Information Community is established by the legislation to provide policy advice on issues arising from more widespread adoption of health IT. These include protecting the privacy and security of information in electronic format, fostering public understanding of health IT, and defining appropriate uses of health IT, among other policy issues. The Community's policy recommendations are essential to the success of widespread adoption of interoperable health information technology.

With respect to the American Health Information Community policies, the committee encourages the entity to ensure the application of appropriate uses of a nationwide health information network including improving the quality of care in rural and frontier communities, reducing health disparities, and fostering the understanding of health information technology among U.S. populations and subpopulations. Policies must incorporate input from health care consumers.

ADOPTION AND EFFECT OF STANDARDS

The bill directs the Partnership, on an ongoing basis, to recommend new standards for the electronic exchange of health information and modifications to existing standards, identify deficiencies and omissions in existing standards, and identify duplication and overlap in existing standards. The bill directs the President to provide for the adoption by the Federal Government of any standard or implementation specification recommended by the Partnership within 90 days after the issuance of such recommenda-

tion. The bill specifies the Secretary, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies, jointly review such recommendations.

The committee believes that when private entities contract with the government to provide health care services, those entities should be able to exchange interoperable information with the Federal Government. To accomplish this under their contracts, private entities must adopt the same standards as the Federal Government. However, this requirement only applies to the external exchange of information. The committee does not intend for private entities to have to adopt the government's standards for their internal business processes, even if those processes ultimately support the exchange of information under the contract.

Not later than 1 year after the adoption by the Federal Government of a recommended standard, no Federal agency shall expend Federal funds for the purchase of any form of health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information that is not consistent with applicable standards adopted by the Federal Government. The committee believes it is critical that the Federal Government comply with the data standards recommended by the Partnership in order to create a nationwide interoperable health information technology infrastructure. Pilot testing of standards is important to ensuring that they are usable and practical. For this reason, the committee included a provision to allow, but not require, the pilot testing of any standard before its adoption.

The legislation requires the Secretary of HHS to implement procedures to enable the Department to accept the electronic submission of data. Participation in the electronic submission of reports utilizing standards is voluntary for private entities, but the Department shall permit such submission. The provision is intended to provide private entities the option of submitting data electronically so that reporting becomes simply another function of an interoperable health information technology system.

The adoption of standards is an important component of establishing consistent and common content and communication between health information technology systems and consistent and common use of adopted standards is another vital piece of establishing a nationwide interoperable health information system. This bill directs the Secretary or his designee, based upon the recommendation of the Partnership, to establish criteria for the implementation and certification of standards adopted by the Federal Government. Additionally, the bill authorizes the Secretary to recognize a private entity to assist with the development of criteria for the implementation of the standards and certification of products for compliance with the standards.

It is the committee's intent to work with the Administration and ensure that this legislation complements steps the Administration has taken towards ensuring interoperable health IT by 2014.

IMPROVING THE QUALITY OF HEALTH CARE

The committee believes that the use of health information technology will help to improve the quality of health care in the prevention and management of chronic disease, improve health care qual-

ity for all populations including rural and frontier communities, medically underserved communities, and communities at risk for health disparities. The committee strongly believes that fostering the development and use of health care quality measures will benefit from collaboration with multi-stakeholder groups that reflect the diversity of the U.S. population.

The Federal Government possesses a significant amount of publicly financed information that could be used to dramatically improve health care quality and making care more affordable for all Americans. Several businesses and health insurance plans in the private sector already utilize their own data to compare and examine the cost and effectiveness of the care their workers and beneficiaries are receiving. The legislation expands this research effort by allowing qualified organizations to access defined Federal health care data to determine more effective and affordable health care solutions, while placing a premium on the privacy and security of patients. The bill authorizes the release of de-identified patient data, reimbursement claims data and survey data maintained by the programs administered by the Secretary to qualified organizations, known as Quality Reporting Organizations (QROs). QROs can then use this data to analyze and develop reports on the cost and quality of health care while including necessary safeguards to protect patient privacy. These reports can be requested by private sector organizations to measure health care quality and costs in a community. Any reports or results derived from this data must be released to the public within 1 year, including detailed information on the methodology, standards and measures of quality used in developing the reports.

In every instance beneficiary privacy is ensured by requiring QROs to comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act. To further ensure beneficiary protection, the bill also requires a privacy review by the Secretary of any analytical report prepared by a QRO prior to its release.

In addition, the legislation ensures that the Secretary permits researchers to access Federal health care data for research provided they comply with appropriate criteria as established by the Secretary.

This legislation directs the Secretary, to develop, adopt and utilize quality measures for the purpose of measuring the quality and efficiency of health care that patients receive. The bill directs the Secretary to designate a single entity to promote the development of quality measures and provide the Secretary with advice and recommendations on the key elements and priorities of a national system for health care performance measurement. In carrying out its duties, the designated entity shall ensure that such measures are evidence-based, reliable, and valid and include measures of clinical process and outcomes, patient experience, efficiency, and equity, as well as measures to assess the effectiveness, timeliness, patient self-management, patient centeredness, and safety of care received by patients. Further, the bill directs the designated entity to give priority to measures with the greatest impact for improving performance and efficiency, measures that may be rapidly implemented, measures that help consumers and patients make informed decisions about their care, measures that apply to multiple

services furnished by different providers, measures that can be integrated into the technology standards setting and certification process.

The RAND Institute reports that patients receive care that is appropriate to their condition only 55 percent of the time and best clinical practices take, on average, 17 years to reach the bedside. The committee finds that the development and adoption of a quality measurement system and its integration with the interoperable health information technology system under this legislation is a critical step in eradicating these deficiencies and improving the quality of health care that all Americans receive.

In developing and updating the quality measures, the Secretary shall enter an arrangement with a private entity to receive advice and recommendations with regard to the development and updating of quality measures. The committee intends the development and updating of the quality measures to recognize those established measurement sets that have gone through a multi-stakeholder, open and accountable process and are currently in use by both the Secretary and the private sector, including the Health Plan Employer Data and Information Set and the Consumer Assessment of Health Plans. It is the intention of the committee to avoid the duplication of these established measures and expects that the Secretary will adopt these measure sets and additions to them. The committee intends the widespread adoption and use of measures developed pursuant to this legislation adopted through the development and updating of the quality measurement system.

The legislation also requires reporting of quality measures by entities receiving grants and loans and allows the Secretary to aggregate, analyze and disseminate quality data for the purposes of providing information to consumers, professionals, officials and researchers.

LOWERING THE BARRIERS TO IMPLEMENTATION OF HEALTH IT

The committee recognizes that a major barrier to widespread adoption of health information technology in the U.S. health care system is the high cost of such technology. The typical cost of purchasing a robust health information technology system for a solo or group practitioner is estimated to be thousands of dollars per provider. In addition to this, there are typically ongoing system maintenance and management costs that must be borne. In the hospital setting, costs vary widely. Nonetheless, purchasing a robust health information technology system, conducting training of personnel, integrating a new health information technology system into legacy computerized systems, and purchasing technical support services can cost millions of dollars for a community hospital of average size.

Most experts estimate that the widespread adoption of health information technology will result in a substantial cost savings over time in our health care system. While providers must bear the full cost of acquiring these systems, a large part of these economic savings will accrue to health insurers and large integrated health care systems, rather than to physicians in office practices or smaller community hospitals.

Many physicians and community hospitals, community health centers and other provider organizations operate with small finan-

cial margins and have difficulty affording modern health information technology systems for use in these clinical settings. Because of the current cost and segmented reimbursement, rates of adoption of modern health information technology in the United States are very low.

In order to address the health information technology "adoption gap" in the United States, S.1693 authorizes three grant programs that will carefully target financial support to health care providers and consortia for the purpose of facilitating the adoption of interoperable health information technology. For the purposes of this act, within the definition of health care provider, the term "laboratory" is intended to include not-for-profit blood centers. The bill leaves to the discretion of the Secretary the allocation of the funding among the three programs.

In addition, the greatest improvements in quality of health care and cost savings will be realized when all elements of the health care system are electronically connected and speak a common technical language—that is they are interoperable. For this reason, each grant program requires that each grant recipient acquire only qualified health information technology systems that are capable of supporting common technical standards and full interoperability and reporting performance on quality measures adopted by the Federal Government under this legislation.

The first grant program will award grants, on a competitive basis, to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology systems to improve the quality and efficiency of health care. Awards will be made by the Secretary. Grant recipients must provide matching funds equal to $1 for each $3 of Federal funds provided under the grant.

Because the committee recognizes the importance of targeting scarce Federal resources where they are most needed, this grant program will give preference to providers that may be least likely to have the capital to acquire health information technology in the absence of a grant—those that are located in medically underserved areas. The committee also recognizes that while there are immediate improvements in quality of care and error reduction with the use of health information technology such as electronic health records, the full benefits of implementing such systems will only be realized when individual provider's systems are all interconnected and patient information will be available when and where it is needed. Thus, this grant program will also give preference to providers that will link, to the extent practicable, their health information system to local or regional health information systems. The bill also gives preference to those grantees that enhance the development of a "medical home" for patients. For too many patients, care is scattered and uncoordinated. Health IT offers the opportunity to bring greater coordination and cohesion to medical treatment, thus improving outcomes and reducing disparities.

In order to maximize the utility of health information technology systems acquired under this grant program in improving and measuring quality of care, grant recipients will be required to report on quality measures adopted by the Federal Government under this bill.

The second program will award grants on a competitive basis to States for the establishment of State programs that will offer loans to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology. To be eligible to receive such a grant, States must establish a State loan fund and submit an application to the Secretary with a strategic plan for awarding loans to eligible entities. State loan programs will be required to stipulate that preference in awarding loans will be given to providers who will link, to the extent practicable, their health information system to local or regional health information systems. States will be required to match $1 for every $1 of Federal funds provided under the grant. The Secretary may give preference to States that adopt value-based purchasing programs to improve health care quality.

To maximize the likelihood that scarce Federal resources will be spent on projects with the greatest likelihood of success, recipients of loans will also be required to consult as necessary with the Health Information Technology Resource Center—established in this bill—that will provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and use effectively interoperable health information technology.

To maximize the utility of health information technology systems acquired under this loan program in improving and measuring quality of care, loan recipients will be required to report on quality measures adopted by the Federal Government under this bill.

States may use grant funds to make loans directly to providers or may use funds to securitize additional loans or bonds, thereby augmenting the total amount of capital available in the program to lend to providers. In addition, State programs may accept voluntary contributions from private entities that may have a strong interest in expanding adoption of health information technology among health care providers in their State or local area. As an incentive for private entities to contribute voluntarily to the loan program, programs may publicize the names of private entities that make contributions. The committee sees a positive marketing value associated with this public recognition of responsible corporate citizenship.

The third program allows the Secretary to award competitive grants to implement regional or local health information technology plans that improve health care quality and efficiency through the use of interoperable health information technology compliant with technology standards and the quality measurement system. To receive a grant, eligible entities must be comprised of a consortium of community stakeholders that demonstrate financial need, adopt policies that demonstrate a commitment to open and fair participation, and demonstrate a commitment to improving the quality of health care through the use of interoperable health information technology.

The committee finds that the development and implementation of regional or local health information technology plans is a critical strategy in the Nation's efforts to build a nationwide interoperable health information technology infrastructure. Community exchange of health information through regional or local health information technology plans compliant with standards will maximize the benefits that patients experience from system-wide use of health IT and

minimize costly technology links and retrofitting that would be necessary if health care stakeholders adopt health IT independent of an interoperable regional or local health information technology plan.

However, the committee recognizes that there may be instances in which inclusion of all required stakeholders outlined may not be possible and the legislation provides the Secretary some flexibility in such cases. However, the committee believes that only applications that demonstrate the strongest commitment to a community-wide collaboration through the most extensive partnering feasible be provided funding.

The legislation authorizes $139 million in fiscal year 2008 and 2009, to remain available until expended. The bill leaves to the discretion of the Secretary the allocation of funding authorized for this section among the three programs.

ENSURING THE PRIVACY OF HEALTH INFORMATION

Because the committee believes that protecting the privacy and security of health information is an essential aspect of creating an interoperable health information infrastructure, the bill establishes several important privacy protections. First, the bill recognizes that privacy protections under HIPAA do not directly apply to one set of new entities that have arisen as a result of new health IT. The bill thus applies the regulations promulgated under HIPAA to these entities. The bill also clarifies that individuals have a right, to the extent provided under HIPAA, to inspect and obtain a copy of their medical records in electronic format, and to have a covered entity amend protected health information in an electronic format—a provision that is especially helpful in guarding against medical fraud.

The committee encourages the Office of the National Coordinator for Health Information Technology to ensure that the development and use of health information technology does not adversely affect privacy. The committee encourages the Office of the National Coordinator for Health Information Technology to work with the Department of Justice and the Office of Civil Rights in this effort.

INTEGRATION OF HEALTH IT INTO HEALTH CARE PRACTICE

Another barrier to widespread adoption of interoperable health information is cultural. The committee recognizes that many physicians and hospitals are hesitant to move from paper-based systems to electronic systems. Some physicians have been writing prescriptions by hand for many years and may resist changing to electronic records and prescribing systems.

This committee believes that one way to address this cultural barrier to the widespread adoption of health information technology is to support teaching hospitals and continuing education programs that integrate health information technology in the clinical education of health care professionals. The committee believes that exposing students and residents to effective everyday uses of health IT will lead to a greater adoption by these students and residents in their future medical practice. The bill authorizes the Secretary to award demonstration grants to health professions centers and academic health centers to integrate health IT into clinical education in community settings. To be eligible, grantees must sub-

mit a strategic plan and provide matching funds of at least $1 for every $2 of Federal funding. The Secretary is required to evaluate the program and disseminate the results, and to report annually to Congress. The bill also reauthorizes Telemedicine Incentive Grants through 2010. These grants were established to encourage State licensure bodies to address remote treatment issues.

The bill also amends the Public Health Service Act and directs the Secretary, acting through the Director of the Agency for Health Care Research and Quality, to develop a Health Information Technology Resource Center to provide technical assistance and develop best practices to support and accelerate the efforts of States and health care providers to adopt, implement, and use effectively health information technology that complies with the standards and quality measurement system adopted by the Federal Government. The committee believes it is important to provide a forum for the exchange of knowledge and experience, accelerate the transfer of lessons learned from existing public and private sector initiatives, and assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of interoperable health information technology. The Secretary has begun undertaking the activities outlined in this section of the legislation. It is the committee's intent not to require the duplication of Federal efforts with respect to the establishment of the Center.

The committee believes this legislation integrates technology and quality to create a seamless, efficient health care system for the 21st century. This legislation will help facilitate the widespread adoption of electronic health records to ultimately result in fewer mistakes, lower costs, better care, and greater patient participation in their health and well being.

V. Cost Estimate

Pursuant to Section 402 of the Congressional Budget Act of 1974, the committee estimates the cost of the legislation will be equal to the amounts discussed in the following estimate provided by the Congressional Budget Office.

July 25, 2007.

Hon. Edward M. Kennedy,
Chairman, Committee on Health, Education, Labor, and Pensions, U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1693, the Wired for Health Care Quality Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley.

Sincerely,

Peter R. Orszag.

Enclosure.

S. 1693—Wired for Health Care Quality Act

Summary: CBO estimates that implementing S. 1693 would cost $47 million in 2008 and $317 million over the 2008–12 period, as-

suming appropriation of the necessary amounts. Enacting the bill would have no effect on direct spending or revenues.

On April 27, 2004, the President issued Executive Order 13335, which established within the Office of the Secretary of Health and Human Services (HHS) the position of National Health Information Technology Coordinator. The Secretary subsequently established the Office of the National Coordinator of Health Information Technology (ONCHIT) and the American Health Information Community (AHIC) to support the adoption of health information technology. S. 1693 would amend the Public Health Service Act (PHSA) to codify the establishment and responsibilities of those entities. In addition, the bill would authorize funding for grants to facilitate the widespread adoption of certain health information technology. S. 1693 would authorize the appropriation of $150 million for 2008 and $150 million for 2009 for those activities.

S. 1693 also would require the Agency for Healthcare Research and Quality (AHRQ) to establish a Health Information Technology Resource Center to provide technical assistance to support the adoption of health information technology, authorize AHRQ to award grants to develop and test quality measures, and extend through 2009 authorization for a program to provide telemedicine grants. CBO estimates that implementing those provisions would require the appropriation of $11 million for 2008 and $25 million over the 2008–12 period.

S. 1693 contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would limit the application of State and local law. However, CBO estimates that the net costs of the mandate would be minimal and far below the threshold established in UMRA ($66 million in 2007, as adjusted for inflation). In general, the bill would benefit State, local, and tribal governments and any costs they incur as a result of participating in the grant programs would result from complying with conditions of Federal assistance. The bill contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated cost of S. 1693 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—					
	2007	2008	2009	2010	2011	2012
SPENDING SUBJECT TO APPROPRIATION						
Spending under Current Law:						
Estimated Budget Authority[1]	61	0	0	0	0	0
Estimated Outlays	18	28	12	2	0	0
Proposed Changes:						
Estimated Authorization Level	0	161	161	1	1	1
Estimated Outlays	0	47	119	105	39	7
Spending under S. 1693:						
Estimated Authorization Level[1]	61	161	161	1	1	1
Estimated Outlays	18	75	131	107	39	7

[1] The 2007 level is CBO's estimate of the funding for the activities of the Office of the National Coordinator of Health Information Technology and the American Health Information Community, including funds reprogrammed by the Secretary of Health and Human Services from other activities.

Basis of estimate: S. 1693 would amend the Public Health Service Act to add title 30—which would deal with health information technology and quality—and to create a Health Information Technology Resource Center and extend authorization for a program to

provide telemedicine grants. For this estimate, CBO assumes that S. 1693 will be enacted near the end of fiscal year 2007, that the necessary amounts will be appropriated each year, and that outlays will follow historical patterns for similar activities of the Department of Health and Human Services. CBO estimates that implementing those provisions would cost $47 million in 2008 and $317 million over the 2008–12 period.

Health Information Technology and Quality

The National Coordinator of Health Information Technology serves as the senior advisor to the Secretary of HHS and the President on all health information technology programs and initiatives, and is responsible for:

- Developing and maintaining a strategic plan to guide the nationwide implementation of electronic health records in both the public and private health care sectors;
- Coordinating spending by Federal agencies for health information technology programs and initiatives; and
- Coordinating outreach activities to private industry and serving as the catalyst for change in the health care industry.

In June 2005, the Secretary announced the creation of the American Health Information Community, a public-private collaboration to provide a forum for public and private interests to recommend specific actions that will accelerate the widespread adoption of electronic records and other health information technology. Based on information provided by the Department of Health and Human Services, CBO estimates that $61 million is available in 2007 for the activities of ONCHIT and AHIC ($42 million from funds appropriated to the Secretary and $19 million from funds reprogrammed from other activities).

S. 1693 would add title 30 to the Public Health Service Act to specify the responsibilities of ONCHIT, AHIC, and a new organization—the Partnership for Health Care Improvement. The current responsibilities of AHIC would be divided between AHIC and the Partnership, with AHIC focusing on development of policy and the Partnership focusing on the technical aspects of developing and promoting the adoption of health information technology.

The bill also would establish several grant programs to promote the adoption of health information technology.

For most of the activities under title 30, S. 1693 would specify the amounts authorized to be appropriated for fiscal years 2008 and 2009: $5 million in each year for ONCHIT, $2 million in each year for the Partnership, $2 million in each year for AHIC, and $141 million in each year for grant programs. Those specified amounts total $150 million in each of fiscal years 2008 and 2009. In addition, the bill would authorize the Secretary, acting through AHRQ, to make grants to support the development and testing of quality measures. CBO estimates the necessary funding for those grants would amount to $1 million for 2008 and $5 million over the 2008–12 period. Thus, CBO estimates that the necessary funding for activities under title 30 would total $151 million for fiscal year 2008 and $305 million over the 2008–12 period.

Of the $141 million in specified funding for grant programs in each of fiscal years 2008 and 2009, $139 million a year would be

allocated to three grant programs—for health care providers, States, and to implement regional or local plans for the exchange of health information—to facilitate the adoption of health information technology, and $2 million a year would be allocated to a fourth grant program to develop academic curricula integrating health information technology systems into the clinical education of health professionals.

The bill would limit eligibility for the grants to health care providers to providers that demonstrate significant financial need. Those providers would be required to provide $1 of matching funds for every $3 of Federal grant funds, and they could use the funds to purchase and enhance the utilization of health information technology and for training personnel in the use of the technology.

States would be eligible for grants that would fund the establishment of State programs for loans to health care providers to facilitate the purchase and use of health information technology. States would have to provide $1 of matching funds for every $1 of Federal grant funds.

The grants to implement regional or local plans for the exchange of health information would require $1 of matching funds for every $2 of Federal grant funds.

Other provisions

In addition to adding title 30 to the Public Health Service Act, S. 1693 would amend that act to establish a Health Information Technology Resource Center to provide technical assistance to support the adoption of health information technology, and it would extend through 2009 authorization for a program to provide telemedicine grants. The Center would be administered by AHRQ, and the telemedicine grants would be administered by the Health Resources and Services Administration (HRSA). CBO estimates that implementing those provisions would require additional appropriations for 2008 and 2009 of $5 million a year for the Center and $5 million a year for HRSA.

Intergovernmental and private-sector impact: S. 1693 would deem an operator of a health information electronic database a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). With some exceptions HIPAA preempts State laws that impose standards less stringent than the Federal standard. Therefore, State standards with respect to an operator of a health information database that are less stringent than the new Federal standard would be preempted by the bill. That preemption would be an intergovernmental mandate as defined in UMRA because it would limit the application of State and local law. However, CBO estimates that the net costs of the mandate would be minimal and far below the threshold established in UMRA ($66 million in 2007, as adjusted for inflation).

The bill also would authorize grants to States and public health entities to assist them with purchasing information technology systems to improve the delivery of health care. Public institutions of higher education also would benefit from grants authorized in the bill to develop academic curricula or analyze data. Any costs those governments or institutions incur, including matching funds, would result from complying with conditions of Federal assistance.

The bill contains no private-sector mandates as defined in UMRA.

Estimate prepared by: Federal costs: Tom Bradley; Impact on state, local, and tribal governments: Lisa Ramirez-Branum; Impact on the private sector: Stuart Hagen.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

VI. Application of Law to the Legislative Branch

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

VII. Regulatory Impact Statement

Pursuant to the requirements of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the committee has determined that the bill will not have a significant regulatory impact.

VIII. Section-by-Section Analysis

Section 1. Short title

Wired for Health Care Quality Act.

Section 2. Improving Health Care Quality, Safety, and Efficiency

Amends the Public Health Service Act by adding at the end: "Title XXX—Health Information Technology and Quality".

Section 3001. Definitions

"Community," "Health Care Provider," "Health Information," "Health Plan," "Individually Identifiable Health Information," "Laboratory," "National Coordinator," "Partnership," "Qualified Health Information Technology," and "State".

Section 3002. Office of the National Coordinator for Health Information Technology

Section 3002 establishes within the office of the Secretary an Office of the National Coordinator for Health Information Technology and defines its responsibilities. The Office will ensure coordination of health information technology initiatives across programs of the Department of Health and Human Services and related government agencies. It will create a strategic plan for the implementation of an interoperable health information technology infrastructure with the purpose of reviewing Federal health information technology investments with measurable outcome goals for health information technology to assess progress within the Department of HHS and other Federal agencies. It will review Federal purchases of health IT to ensure compliance with the Partnership's plans for health IT, as well as the implementation of health IT systems by other organizations in order to draw lessons for other health care providers. The Office will also study how to use these systems to utilize health IT to improve quality of care and chronic disease management. The Office will further work to increase the penetration of health IT in communities with health disparities. In order

to publicize its activities, the Office will maintain a Web site which publishes a schedule for the assignment of significant use cases, recommendations of the Community, quality measures, and identifies potential funding sources for health information technology systems. The Office will also devise a plan to replace itself after this section's provisions sunset on September 30, 2014.

Section 3003. Partnership for Health Care Improvement; Standards and technology

Section 3003 establishes the public-private Partnership for Health Care Improvement comprised of individuals from the public and private sectors. This Partnership shall recommend standards, implementation specifications, and certification criteria for electronic exchange of health information for adoption by the Federal Government and voluntary adoption by private entities. The Partnership will hold public hearings for comment on its recommendations, and ensure that all its recommendations are compliant with HIPAA in order to protect patient privacy. In addition to issuing recommendations, the Partnership will also serve as a forum for technical experts in the field of health information technology. The governance rules of the Partnership and information about its meetings will be publicly available on a Web site maintained by the Partnership.

Members of the Partnership will serve 3-year terms. The membership will include representatives of consumer or patient organizations, privacy experts, security experts, health care providers, health insurance representatives, insurance purchasers, and information technology vendors, with the National Coordinator serving as the liaison among the parties and to the Federal Government. The Majority Leader of the Senate, the Minority Leader of the Senate, the Speaker of the House, and the Minority Leader of the House will each appoint a member of the Partnership. Partnership recommendations shall be reviewed by the Secretaries of HHS, Veterans Affairs, Defense, and related agencies. If appropriate, the President shall provide for the Federal Government's adoption of the recommendations.

Section 3004. American Health Information Community—Policies

Section 3004 creates a committee known as the American Health Information Community, which makes recommendations on policy issues related to health IT. These recommendations shall be designed for adoption by the Federal Government and the voluntary adoption by private entities. The recommendations of the Community shall address the following issues among others:

1. Protection of patients' control of the acquisition, use and release of their health information;
2. Protection of individually identifiable health information by notifying patients of wrongful disclosure and by allowing patients to access their own health information;
3. Identification of appropriate uses of the national health information network, including collection of quality data and public reporting, biosurveillance, medical research, and drug safety;
4. Increasing the involvement of health care providers and staff in health IT systems design and implementation;

5. Fostering the public understanding of health information technology; and

6. Promulgation of a strategy to use health IT to improve chronic disease management.

All recommendations of the Community shall be consistent with HIPAA to ensure the protection of patient privacy. The Community will hold public hearings for comment on its recommendations, and publish its findings in the Federal Register and the Web site of the National Coordinator.

The membership of the Community will be chosen by a variety of officials to represent a wide range of viewpoints. It will be composed of three members appointed by the Secretary, including one representative of DHHS. One will be appointed by the Secretary of Veterans Affairs and represent DVA. The majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives will each appoint one member. Nine members will be appointed by the Comptroller General to represent different parts of the health care community, including representatives of health care providers, consumer groups, insurance companies, technology vendors and organized labor. There will also be experts in privacy and security, improving health care in disadvantaged areas, and health care quality measurement. All members serve three year terms.

The Community will be able to draw both on outside expertise and Federal resources. Outside entities shall advise the Community on issues of health privacy and security, patient safety, ethics, research data exchange, and information technology standards. The Federal Government shall provide the Community access to resources from the Library of Congress, Federal agencies, and elected representatives. The Federal Advisory Committee Act shall apply to the Community.

Two million dollars is authorized to be appropriated to support the Community's activities in fiscal year 2008 and fiscal year 2009. The provisions applying to the Community will sunset on September 20, 2014.

Section 3005. Federal purchasing and data collection

Section 3005 prohibits the Federal Government from purchasing health IT systems that do not comply with the adopted recommendations of the Partnership. Within 3 years, the Federal Government will also establish a common format for reporting health information. However, all Federal standards shall be voluntary with respect to private entities. Private entities contracting with the Federal Government shall adopt the government's standards for their activities under Federal contract.

Section 3006. Quality and efficiency reports

Section 3006 provides that the government contract with three Quality Reporting Organizations (QROs) to utilize Federal health care data for the purpose of producing reports on health care quality. The Secretary will draft regulations for QROs to request heath quality reports in exchange for a reasonable fee. These three outside organizations must have expertise in the analysis of such data and have the technological infrastructure appropriate to utilize Federal health IT standards. In order to ensure patient privacy,

the QROs must ensure patient privacy by adhering to HIPAA standards in addition to those of sections 552 and 552a of U.S.C. Title 5. Moreover, these protections continue to apply if the organization's contract with the Federal Government is terminated. Researchers will be able to access the information provided they comply with guidelines established by the Secretary. The QROs are also required to protect the security of patient data.

TITLE II—FACILITATING THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY

Section 201. Facilitating the widespread adoption of interoperable health information technology

Title XXX of the Public Health Service Act as created by Section 101 is further amended by adding at the end the following provisions:

Section 3008. Facilitating the widespread adoption of interoperable health information technology

Section 3008 establishes three grant programs at HHS: a grant program for health IT adoption in health care facilities, a competitive grant program for State loan programs in health IT, and a program to supply funds for the implementation of regional and local health IT network. To fund these three programs, $139 million is authorized to be appropriated. The program for health provider IT adoption gives grants directly to health care providers for four purposes: the purchase of qualified health IT systems, personnel training in these systems, increasing utilization of health IT and improving chronic disease management. The State program allows States to apply for grants to State qualified health IT loan funds to match State contributions to these programs. They may not directly duplicate other Federal spending in the bill. The program for regional and local health IT allows a wide range of entities to jointly apply for grants to produce regional and local health IT networks. These entities may include health care providers, health insurance companies, patient advocacy groups, and others. These programs have four common eligibility requirements:

1. Adoption of standards consistent with those approved by the government;
2. Matching of Federal contributions with other funds: $1 for every $3 of Federal contributions in health IT adoption grants, $1 for every $1 of Federal contributions in the State loan program, and $1 for every $2 of Federal contributions in the local and regional network program;
3. Notification of individuals if their health information is wrongfully disclosed; and
4. Medical care delivery staff input in system design.

Network grants have the following additional requirements:

1. Integrate stakeholders into local and regional health IT networks when possible;
2. Practice of non-discrimination for all stakeholders in the network;
3. Input of medical care delivery staff in systems design;
4. Features to reduce barriers to provider implementation of health IT; and

5. Draft plans to protect patient privacy and security, to maintain compliance with Federal standards, and to ensure the financial sustainability of the networks.

Section 3009. Demonstration program to integrate information technology into clinical education

Section 3009 establishes a demonstration program to give grants to institutions of medical education in order to integrate health IT into their curricula. These projects must involve two or more medical disciplines and match 50 percent of the Federal contribution with money from other sources. The institutions must report to the Secretary within 1 year on the effectiveness of the projects. Two million dollars is authorized to be appropriated for this purpose in fiscal year 2008 and fiscal year 2009. The provisions of this program sunset on September 30, 2012.

TITLE III—IMPROVING THE QUALITY OF HEALTH CARE

Section 301. Consensus process for the adoption of quality measures for use in the Nationwide Interoperable Health Information Technology Infrastructure

Title XXX of the Public Health Service Act, as amended by section 201, is further amended by adding at the end the following:

Section 3010. Fostering development and use of health quality measures

Section 3010 requires the Secretary of HHS to develop and use health care quality measures for the purpose of measuring the quality and efficiency of health care patients receive. The Secretary shall designate an organization to promote the development of quality measures and provide the Secretary with advice and recommendations on the key elements and priorities of a national system for health care performance measurement. The organization will endorse national consensus quality measures and recommend quality measures to the Secretary of HHS for adoption and use. The organization will further coordinate setting standards for the development and testing of quality measures. The quality measures adopted by the Secretary will be integrated into the Partnership's certification process. In addition, the organization will also promote the development of electronic health records that allow automatic collection, aggregation and transmission of quality measurements.

The designated organization itself must be a private nonprofit governed by a president and a board of directors which represent health care providers, health plans, patients or consumers, health care purchasers or employers, and health care practitioners. The board of directors should have experience with urban and rural health care issues, State and local health programs, safety net and quality issues and be experts in health information technology standards and technology assessment. The organization will conduct business in an open and transparent fashion which allows for public comment.

The quality measures endorsed by the organization must be evidence-based, and must include measures of clinical process and outcomes, patient experience, efficiency, equity, patient centeredness, patient self-management, safety, underuse and over-

use. Priority is given to quality measures with the greatest potential for improving care, that may be implemented rapidly, that inform patient choice, that can be integrated into the certification process, that facilitate physician decision-making using health IT, and that apply to multiple health services. The organization shall establish procedures to ensure appropriate risk adjustment and for the maintenance or quality measures. The Secretary may award grants to organizations to support the development and testing of quality measures.

Section 3011. Adoption and use of quality measures; Reporting

In Section 3011, the Secretary is given the responsibility of selecting quality measures for use and ensuring that these measures are integrated into the bill's overall health IT framework. The Secretary will decide which quality measures shall be adopted from those recommended to him by multi-stakeholder groups and endorsed by the designated organization. Moreover, the Secretary shall ensure that all adopted measures are integrated into the standards adopted pursuant to Section 3005. In addition, all quality measures are required to complement quality measures for programs in Titles XVIII, XIX, and XXI of the Social Security Act and not conflict with the needs of programs under that title as determined by the Administrator of the CMS.

The Secretary shall also devise regulations to allow the distribution, aggregation and analysis of selected quality measures.

TITLE IV—PRIVACY AND SECURITY

Section 401. Privacy and security

Title XXX of the Public Health Service Act, as amended by section 301, is further amended by adding at the end the following:

Section 3013. Ensuring privacy and security

Section 3013 introduces new privacy protections for health IT. The section extends HIPAA privacy protections to cover health records stored in certain health information electronic databases. It further recognizes the right of individuals to look at their health records stored in electronic form to the extent provided under HIPAA. Victims of medical fraud are also recognized as having the right to view the fraudulently entered information and amend their records to the extent provided under HIPAA.

TITLE V—MISCELLANEOUS PROVISIONS

Section 501. GAO study

Section 501 stipulates that within a year of an enactment, the Comptroller General submit a report to Congress detailing circumstances in which it is necessary and workable to require health plans, health care clearinghouses, and health care providers to notify parents of wrongful disclosure of individually identifiable health information.

Section 502. Health Information Technology Resource Center

Section 502 amends Section 914 of the Public Health Service Act to include a requirement that the Secretary develop a Health Information Technology Resource Center to serve as a forum to explore

lessons learned from public or private sector initiatives, assemble evidence concerning adoption of health information technology, establish local and regional networks, and provide for exchange of electronic health data.

Section 503. Facilitating the provision of telehealth services across state lines

Section 503 reauthorizes section 330L of the Public Health Service Act: Telemedicine; Incentive Grants Regarding Coordination Among States. Section 330L allows the Secretary of HHS to make grants to States that have adopted regional State reciprocity agreements. Such sums as may be necessary are authorized to be appropriated for fiscal year 2008 and fiscal year 2009.

IX. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

[SEC. 330L. [254c–18] TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.

[(a) In General.—The Secretary may make grants to State professional licensing boards to carry out programs under which such licensing boards of various States cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine.

[(b) Authorization of Appropriations.—For the purpose of carrying out subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2002 through 2006.]

SEC. 330L. TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.

(a) Facilitating the Provision of Telehealth Services Across State Lines.—The Secretary may make grants to States that have adopted regional State reciprocity agreements for practitioner licensure, in order to expedite the provision of telehealth services across State lines.

(b) Authorization of Appropriations.—For the purpose of carrying out subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2008 and 2009.

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SEC. 914. [299b–3] INFORMATION SYSTEMS FOR HEALTH CARE IMPROVEMENT.

(a) In General.—* * *

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(d) Health Information Technology Resource Center.—

(1) IN GENERAL.—The Secretary, acting through the Director, shall develop a Health Information Technology Resource Center (referred to in this subsection as the "Center" to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology in compliance with sections 3003 and 3010.

(2) PURPOSES.—The purposes of the Center are to—

(A) provide a forum for the exchange of knowledge and experience;

(B) accelerate the transfer of lessons learned from existing public and private sector initiatives, including those currently receiving Federal financial support;

(C) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of interoperable health information technology;

(D) provide for the establishment of regional and local health information networks to facilitate the development of interoperability across health care settings and improve the quality of health care;

(E) provide for the development of solutions to barriers to the exchange of electronic health information; and

(F) conduct other activities identified by the States, local, or regional health information networks, or health care stakeholders as a focus for developing and sharing best practices.

(3) SUPPORT FOR ACTIVITIES.—To provide support for the activities of the Center, the Director shall modify the requirements, if necessary, that apply to the National Resource Center for Health Information Technology to provide the necessary infrastructure to support the duties and activities of the Center and facilitate information exchange across the public and private sectors.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the duplication of Federal efforts with respect to the establishment of the Center, regardless of whether such efforts were carried out prior to or after the enactment of this subsection.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2008 and 2009 to carry out this section.

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TITLE XXIX—LIFESPAN RESPITE CARE

SEC. 2901. [300ii] DEFINITIONS.

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SEC. 2905. [300ii–4] AUTHORIZATION OF APPROPRIATIONS.

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TITLE XXX—HEALTH INFORMATION TECHNOLOGY AND QUALITY

SEC. 3001. DEFINITIONS; REFERENCE.

(a) IN GENERAL.—In this title:

(1) COMMUNITY.—The term "Community" means the American Health Information Community established under section 3004.

(2) HEALTH CARE PROVIDER.—The term "health care provider" means a hospital, skilled nursing facility, home health entity, health care clinic, federally qualified health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a practitioner (as defined in section 1842(b)(18)(CC) of the Social Security Act), a health facility operated by or pursuant to a contract with the Indian Health Service, a rural health clinic, and any other category of facility or clinician determined appropriate by the Secretary.

(3) HEALTH INFORMATION.—The term "health information" has the meaning given such term in section 1171(4) of the Social Security Act.

(4) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—The term "health insurance plan" means—

(i) a health insurance issuer (as defined in section 2791(b)(2));

(ii) a group health plan (as defined in section 2791(a)(1)); and

(iii) a health maintenance organization (as defined in section 2791(b)(3)); or

(iv) a safety net health plan.

(B) SAFETY NET HEALTH PLAN.—The term "safety net health plan" means a managed care organization, as defined in section as 1932(a)(1)(B)(i) of the Social Security Act—

(i) that is exempt from or not subject to Federal income tax, or that is owned by an entity or entities exempt from or not subject to Federal income tax; and

(ii) for which not less than 75 percent of the enrolled population receives benefits under a Federal health care program (as defined in section 1128B(f)(1) of the Social Security Act) or a health care plan or program which is funded, in whole or in part, by a State (other than a program for government employees).

(C) REFERENCES.—All references in this title to "health plan" shall be deemed to be references to "health insurance plan."

(5) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term "individually identifiable health information" has the meaning given such term in section 1171 of the Social Security Act.

(6) LABORATORY.—The term "laboratory" has the meaning given such term in section 353.

(7) NATIONAL COORDINATOR.—The term "National Coordinator" means the National Coordinator of Health Information Technology appointed pursuant to section 3002.

(8) PARTNERSHIP.—The term "Partnership" means the Partnership for Health Care Improvement established under section 3003.

(9) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term "qualified health information technology" means a computerized system (including hardware and software) that—

(A) protects the privacy and security of health information;

(B) maintains and provides permitted access to health information in an electronic format;

(C) with respect to individually identifiable health information maintained in a designated record set, preserves an audit trail of each individual that has gained access to such record set;

(D) incorporates decision support to reduce medical errors and enhance health care quality;

(E) complies with the standards adopted by the Federal Government under section 3003;

(F) has the ability to transmit and exchange information to other health information technology systems and, to the extent feasible, public health information technology systems; and

(G) allows for the reporting of quality measures adopted under section 3010.

(10) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(b) REFERENCES TO SOCIAL SECURITY ACT.—Any reference in this section to the Social Security Act shall be deemed to be a reference to such Act as in effect on the date of enactment of this title.

SEC. 3002. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

(a) ESTABLISHMENT.—There is established within the office of the Secretary, the Office of the National Coordinator of Health Information Technology. The National Coordinator shall be appointed by the Secretary in consultation with the President, and shall report directly to the Secretary.

(b) PURPOSE.—The Office of the National Coordinator shall be responsible for—

(1) ensuring that key health information technology initiatives are coordinated across programs of the Department of Health and Human Services;

(2) ensuring that health information technology policies and programs of the Department of Health and Human Services are coordinated with such policies and programs of other relevant Federal agencies including Federal commissions and advisory committees) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes activities primarily within the areas of its greatest expertise and technical capability;

(3) reviewing Federal health information technology investments to ensure that Federal health information technology programs are meeting the objectives of the strategic plan published by the Office of the National Coordinator of Health Information Technology to establish a nationwide interoperable health information technology infrastructure;

(4) providing comments and advice regarding specific Federal health information technology programs, at the request of Office of Management and Budget; and

(5) enhancing the use of health information technology to improve the quality of health care in the prevention and management of chronic disease and to address population health.

(c) ROLE WITH COMMUNITY AND THE PARTNERSHIP.—The Office of the National Coordinator shall—

(1) serve as an ex officio member of the Community, and act as a liaison between the Federal Government and the Community;

(2) serve as an ex officio member of the Partnership and act as a liaison between the Federal Government and the Partnership; and

(3) serve as a liaison between the Partnership and the Community.

(d) REPORTS AND WEBSITE.—The Office of the National Coordinator shall—

(1) develop and publish a strategic plan for implementing a nationwide interoperable health information technology infrastructure;

(2) maintain and frequently update an Internet website that—

(A) publishes the schedule for the assessment of standards for significant use cases;

(B) publishes the recommendations of the Community;

(C) publishes the recommendations of the Partnership;

(D) publishes quality measures;

(E) identifies sources of funds that will be made available to facilitate the purchase of, or enhance the utilization of, health information technology systems, either through grants or technical assistance; and

(F) publishes a plan for a transition of any functions of the Office of the National Coordinator that should be continued after September 30, 2014;

(3) prepare a report on the lessons learned from major public and private health care systems that have implemented health information technology systems, including an explanation of whether the systems and practices developed by such systems may be applicable to and usable in whole or in part by other health care providers; and

(4) assess the impact of health information technology in communities with health disparities and identify practices to increase the adoption of such technology by health care providers in such communities.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the duplication of Federal efforts with respect to the establishment of the Office of the National Coordinator for Health Information Technology, regardless of whether such ef-

forts are carried out before or after the date of the enactment of this title.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2008 and 2009.

(g) SUNSET.—The provisions of this section shall not apply after September 30, 2014.

SEC. 3003. PARTNERSHIP FOR HEALTH CARE IMPROVEMENT-STANDARDS AND TECHNOLOGY.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a public-private Partnership for Health Care Improvement to—

(A) provide advice to the Secretary and the Nation and recommend specific actions to achieve a nationwide interoperable health information technology infrastructure;

(B) make recommendations concerning standards, implementation specifications, and certification criteria for the electronic exchange of health information (including for the reporting of quality data under section 3010) for adoption by the Federal Government and voluntary adoption by private entities;

(C) serve as a forum for the participation of a broad range of stakeholders with specific technical expertise in the development of standards, implementation specifications, and certification criteria to provide input on the effective implementation of health information technology

(D) develop and maintain an Internet web site that—

(i) publishes established governance rules (including a subsequent appointment process);

(ii) publishes a business plan;

(iii) publishes meeting notices at least 14 days prior to each meeting;

(iv) publishes meeting agendas at least 7 days prior to each meeting; and

(v) publishes meeting materials at least 3 days prior to each meeting.

(2) LIMITATION.—The Partnership shall not meet or take any action until an advisory committee charter has been filed with the Secretary and with the appropriate committees of the Senate and House of Representatives for the Community described in section 3004.

(b) MEMBERSHIP.—

(1) APPOINTMENTS.—

(A) IN GENERAL.—The Partnership shall be composed of members to be appointed as follows:

(i) 2 members shall be appointed by the Secretary.

(ii) member shall be appointed by the majority leader of the Senate.

(iii) 1 member shall be appointed by the minority leader of the Senate.

(iv) 1 member shall be appointed by the Speaker of the House of Representatives.

(v) 1 member shall be appointed by the minority leader of the House of Representatives.

(vi) Seven members shall be appointed by the Comptroller General of whom—

(I) one member shall be a representative of consumer or patient organizations;

(II) one member shall be a representative of organizations with expertise in privacy;

(III) one member shall be a representative of organizations with expertise in security;

(IV) one member shall be a representative of health care providers;

(V) one member shall be a representative of health plans or other third party payers;

(VI) one member shall be a representative of information technology vendors; and

(VII) one member shall be a representative of purchasers or employers.

(B) NATIONAL COORDINATOR.—The National Coordinator shall be a member of the Partnership and act as a liaison among the Partnership, the community, and the Federal Government.

(2) CHAIRPERSON AND VICE CHAIRPERSON.—The Partnership shall designate one member to serve as the chairperson and one member to serve as the vice chairperson of the Partnership.

(3) PARTICIPATION.—In appointing members under paragraph (1)(A), and in developing the procedures for conducting the activities of the Partnership, the Partnership shall ensure a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Partnership.

(4) TERMS.—Members appointed under paragraph (1)(A) shall serve for 3 year terms, except that any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve for not to exceed 180 days after the expiration of such member's term or until a successor has been appointed.

(5) OUTSIDE INVOLVEMENT.—The Partnership shall ensure an adequate opportunity for the participation of outside advisors, including individuals with expertise in—

(A) health information privacy;

(B) health information security;

(C) health care quality and patient safety, including individuals with expertise in utilizing health information technology to improve health care quality and patient safety;

(D) medical and clinical research data exchange; and

(E) developing health information technology standards and new health information technology.

(6) QUORUM.—Two-thirds of the members of the Partnership shall constitute a quorum for the purpose of conducting votes.

(c) STANDARDS AND IMPLEMENTATION SPECIFICATIONS.—

(1) SCHEDULE.—Not later than 90 days after the date of enactment of this title, the Partnership shall develop a schedule for the assessment of standards and implementation specifications under this section. The Partnership shall update such schedule annually. The Secretary shall publish such schedule

in the Federal Register and on the Internet website of the Department of Health and Human Services.

(2) FIRST YEAR RECOMMENDATIONS.—Consistent with the schedule published under paragraph (1) and not later than 1 year after date of enactment of this title, the Partnership shall recommend, and the Secretary shall review, such standards and implementation specifications.

(3) ONGOING RECOMMENDATIONS.—The Partnership shall review and modify, as appropriate but at least annually, adopted standards and implementation specifications and continue to recommend additional standards and implementation specifications, consistent with the schedule published pursuant to paragraph (1). The Secretary shall review such modifications and recommendations.

(4) RECOGNITION OF PRIVATE ENTITIES.—The Partnership, in consultation with the Secretary, may recognize a private entity or entities for the purpose of developing and updating standards and implementation specifications to achieve uniform and consistent implementation of the standards adopted by the President under this title. Such entity or entities shall make recommendations to the Partnership consistent with this section.

(5) PUBLICATION.—All recommendations made by the Partnership pursuant to this section shall be published in the Federal Register and on the Internet website of the Office of the National Coordinator.

(6) PILOT TESTING.—The Secretary may conduct, or recognize a private entity or entities to conduct, a pilot project to test the standards and implementation specifications developed under this section in order to provide for the efficient implementation of the standards and implementation specifications described in this subsection prior to issuing such recommendations.

(7) PUBLIC INPUT.—The Partnership shall conduct open public meetings and develop a process to allow for public comment on the schedule and recommendations described in this section. Such process shall ensure that such comments will be submitted within 30 days of the publication of a recommendation under this section.

(8) FEDERAL ACTION.—Not later than 90 days after the issuance of a recommendation from the Partnership under this subsection, the Secretary, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies as determined appropriate by the President, shall jointly review such recommendation. If appropriate, the President shall provide for the adoption by the Federal Government of any standard or implementation specification contained in such recommendation. Such determination shall be published in the Federal Register and on the Internet website of the Office of the National Coordinator within 30 days after such determination is made.

(9) CONSISTENCY.—The standards and implementation specifications described in this subsection shall be consistent with the standards for information transactions and data elements developed pursuant to the regulations promulgated under sec-

tion 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(d) CERTIFICATION.—

(1) DEVELOPING CRITERIA.—The Partnership, in consultation with the Secretary, may recognize a private entity or entities for the purpose of developing and recommending to the Partnership criteria to certify that appropriate categories of health information technology products that claim to be in compliance with applicable standards and implementation specifications adopted under this title have established such compliance.

(2) ADOPTION OF CRITERIA.—The Secretary, based upon the recommendations of the Partnership, shall review, and if appropriate, adopt such criteria.

(3) CONDUCTING CERTIFICATION.—The Secretary may recognize a private entity or entities to conduct the certifications described under paragraph (1) using the criteria adopted by the Secretary under this subsection.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as disrupting existing activities described in subsection (c) or (d).

(f) REQUIREMENT TO CONSIDER RECOMMENDATIONS.—In carrying out the activities described in subsections (c) and (d), the Partnership shall adopt and integrate the recommendations of the Community that are adopted by the Secretary.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $2,000,000 for each of the fiscal years 2008 and 2009.

SEC. 3004. AMERICAN HEALTH INFORMATION COMMUNITY—POLICIES.

(a) ESTABLISHMENT.—There is established a committee to be known as the American Health Information Community. The Community shall—

(1) provide advice to the Secretary and the heads of any relevant Federal agencies concerning the policy considerations related to health information technology;

(2) not later than 1 year after the date of enactment of this title, and annually thereafter, make recommendations concerning a policy framework for the development and adoption of a nationwide interoperable health information technology infrastructure;

(3) not later than 1 year after the date of enactment of this title, and annually thereafter, make recommendation concerning national policies for adoption by the Federal Government, and voluntary adoption by private entities, to support the widespread adoption of health information technology, including—

(A) the protection of individually identifiable health information, including policies concerning the individual's ability to control the acquisition, uses, and disclosures of individually identifiable health information;

(B) methods to protect individually identifiable health information from improper use and disclosures and methods to notify patients if their individually identifiable health information is wrongfully disclosed;

(C) methods to facilitate secure access to such individual's individually identifiable health information;

(D) the appropriate uses of a nationwide health information network including—

(i) the collection of quality data and public reporting;

(ii) biosurveillance and public health;

(iii) medical and clinical research; and

(iv) drug safety;

(E) fostering the public understanding of health information technology;

(F) strategies to enhance the use of health information technology in preventing and managing chronic disease;

(G) policies to incorporate the input of employees of health care providers in the design and implementation of health information technology systems; and

(H) other policies determined to be necessary by the Community; and

(4) serve as a forum for the participation of a broad range of stakeholders to provide input on improving the effective implementation of health information technology systems.

(b) PUBLICATION.—All recommendations made by the Community pursuant to this section shall be published in the Federal Register and on the Internet website of the National Coordinator. The Secretary shall review all recommendations and determine which recommendations shall be endorsed by the Federal Government and such determination shall be published on the Internet website of the Office of the National Coordinator within 30 days after the date on which such endorsement is made.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Community shall be composed of members to be appointed as follows:

(A) 3 members shall be appointed by the Secretary, 1 of whom shall be a representative from the Department of Health and Human Services.

(B) 1 member shall be appointed by the Secretary of Veterans Affairs who shall represent the Department of Veterans Affairs.

(C) 1 member shall be appointed by the Secretary of Defense who shall represent the Department of Defense.

(D) 1 member shall be appointed by the majority leader of the Senate.

(E) 1 member shall be appointed by the minority leader of the Senate.

(F) 1 member shall be appointed by the Speaker of the House of Representatives.

(G) 1 member shall be appointed by the minority leader of the House of Representatives.

(H) Nine members shall be appointed by the Comptroller General of whom—

(i) one member shall be advocates for patients or consumers;

(ii) one member shall represent health care providers;

(iii) one member shall be from a labor organization representing health care workers;

(iv) one member shall have expertise in privacy and security;

(v) one member shall have expertise in improving the health of vulnerable populations;

(vi) one member shall represent health plans or other third party payers;

(vii) one member shall represent information technology vendors;

(viii) one member shall represent purchasers or employers; and

(ix) one member shall have expertise in health care quality measurement and reporting.

(2) CHAIRPERSON AND VICE CHAIRPERSON.—The Community shall designate one member to serve as the chairperson and one member to serve as the vice chairperson of the Community.

(3) NATIONAL COORDINATOR.—The National Coordinator shall be a member of the Community and act as a liaison among the Community, the partnership, and the Federal Government.

(4) PARTICIPATION.—The members of the Community appointed under paragraph (1) shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Community.

(5) TERMS.—

(A) IN GENERAL.—The terms of members of the Community shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy in the membership of the Community that occurs prior to the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has been appointed. A vacancy in the Community shall be filled in the manner in which the original appointment was made.

(6) OUTSIDE INVOLVEMENT.—The Community shall ensure an adequate opportunity for the participation of outside advisors, including individuals with expertise in—

(A) health information privacy and security;

(B) improving the health of vulnerable populations;

(C) health care quality and patient safety, including individuals with expertise in measurement and the use of health information technology to capture data to improve health care quality and patient safety;

(D) ethics;

(E) medical and clinical research data exchange; and

(F) developing health information technology standards and new health information technology.

(7) QUORUM.—Ten members of the Community shall constitute a quorum for purposes of voting, but a lesser number of members may meet and hold hearings.

(d) FEDERAL AGENCIES.—

(1) STAFF OF OTHER FEDERAL AGENCIES.—Upon the request of the Community, the head of any Federal agency may detail, without reimbursement, any of the personnel of such agency to the Community to assist in carrying out the duties of the Com-

munity. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee involved.

(2) TECHNICAL ASSISTANCE.—Upon the request of the Community, the head of a Federal agency shall provide such technical assistance to the Community as the Community determines to be necessary to carry out its duties.

(3) OTHER RESOURCES.—The Community shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The chairperson or vice chairperson of the Community shall make requests for such access in writing when necessary.

(e) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Community, except that the term provided for under section 14(a)(2) of such Act shall be not longer than 7 years.

(f) SUNSET.— The provisions of this section shall not apply after September 20, 2014.

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $2,000,000 for each of fiscal years 2008 and 2009.

SEC. 3005. FEDERAL PURCHASING AND DATA COLLECTION.

(a) COORDINATION OF FEDERAL SPENDING.—

(1) IN GENERAL.—Not later than 1 year after the adoption by the President of a recommendation under section 3003(c)(6), a Federal agency shall not expend Federal funds for the purchase of any new health information technology or health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information if such technology or system is not consistent with applicable standards adopted by the Federal Government under section 3003.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed to restrict the purchase of minor (as determined by the Secretary) hardware or software components in order to modify, correct a deficiency in, or extend the life of existing hardware or software.

(b) VOLUNTARY ADOPTION.—

(1) IN GENERAL.—Any standards and implementation specifications adopted by the Federal Government under section 303(c)(6) shall be voluntary with respect to private entities.

(2) REQUIREMENT.—Private entities that enter into a contract with the Federal Government shall adopt the standards and implementation specifications adopted by the Federal Government under this section for the purpose of activities under such Federal contract.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require that a private entity that enters into a contract with the Federal Government adopt the standards and implementation specifications adopted by the Federal Government under this section with respect to activities not related to the contract.

(c) COORDINATION OF FEDERAL DATA COLLECTION.—Not later than 3 years after the adoption by the Federal Government of a rec-

ommendation as provided for in section 303(c)(6), all Federal agencies collecting health data in an electronic format for the purposes of quality reporting, surveillance, epidemiology, adverse event reporting, research, or for other purposes determined appropriate by the Secretary, shall comply with the standards and implementation specifications adopted under such subsection.

SEC. 3006. QUALITY AND EFFICIENCY REPORTS.

(a) PURPOSE.—The purpose of this section is to provide for the development of reports based on Federal health care data and private data that is publicly available or is provided by the entity making the request for the report in order to—

(1) improve the quality and efficiency of health care and advance health care research;

(2) enhance the education and awareness of consumers for evaluating health care services; and

(3) provide the public with reports on national, regional, and provider- and supplier-specific performance, which may be in a provider- or supplier-identifiable format.

(b) PROCEDURES FOR THE DEVELOPMENT OF REPORTS.—

(1) IN GENERAL.—Notwithstanding section 552(b)(6) or 552a(b) of title 5, United States Code, not later than 12 months after the date of enactment of this section, the Secretary, in accordance with the purpose described in subsection (a), shall establish and implement procedures under which an entity may submit a request to a Quality Reporting Organization for the Organization to develop a report based on—

(A) Federal health care data disclosed to the Organization under subsection (c); and

(B) private data that is publicly available or is provided to the Organization by the entity making the request for the report.

(2) DEFINITIONS.—In this section:

(A) FEDERAL HEALTH CARE DATA.—The term "Federal health care data" means—

(i) deidentified patient enrollment data, reimbursement claims, and survey data maintained by the Secretary or entities under programs, contracts, grants, or memoranda of understanding administered by the Secretary; and

(ii) where feasible, other deidentified patient enrollment data, reimbursement claims, and survey data maintained by the Federal Government or entities under contract with the Federal Government.

(B) QUALITY REPORTING ORGANIZATION.—The term "Quality Reporting Organization" means an entity with a contract under subsection (d).

(c) ACCESS TO FEDERAL HEALTH CARE DATA.—

(1) IN GENERAL.—The procedures established under subsection (b)(1) shall provide for the secure disclosure of Federal health care data to each Quality Reporting Organization.

(2) UPDATE OF INFORMATION.—Not less than every 6 months, the Secretary shall update the information disclosed under paragraph (1) to Quality Reporting Organizations.

(d) QUALITY REPORTING ORGANIZATIONS.—

(1) IN GENERAL.—

(A) THREE CONTRACTS.—Subject to subparagraph (B), the Secretary shall enter into a contract with 3 private entities to serve as Quality Reporting Organizations under which an entity shall—

(i) store the Federal health care data that is to be disclosed under subsection (c); and

(ii) develop and release reports pursuant to subsection (e).

(B) ADDITIONAL CONTRACTS.—If the Secretary determines that reports are not being developed and released within 6 months of the receipt of the request for the report, the Secretary shall enter into contracts with additional private entities in order to ensure that such reports are developed and released in a timely manner.

(2) QUALIFICATIONS.—The Secretary shall enter into a contract with an entity under paragraph (1) only if the Secretary determines that the entity—

(A) has the research capability to conduct and complete reports under this section;

(B) has in place—

(i) an information technology infrastructure to support the database of Federal health care data that is to be disclosed to the entity; and

(ii) operational standards to provide security for such database;

(C) has experience with, and expertise on, the development of reports on health care quality and efficiency; and

(D) has a significant business presence in the United States.

(3) CONTRACT REQUIREMENTS.—Each contract with an entity under paragraph (1) shall contain the following requirements:

(A) ENSURING BENEFICIARY PRIVACY.—

(i) HIPAA.—The entity shall meet the requirements imposed on a covered entity for purposes of applying part C of title XI and all regulatory provisions promulgated thereunder, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(ii) PRIVACY.— The entity shall provide assurances that the entity will not use the Federal health care data disclosed under subsection (c) in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of and individual's individually identifiable health information.

(B) PROPRIETARY INFORMATION.—The entity shall provide assurances that the entity will not disclose any negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, obtained by health care providers or suppliers or health care plans, or any other proprietary cost information.

(C) DISCLOSURE.—The entity shall disclose—

(i) any financial, reporting, or contractual relationship between the entity and any health care provider or supplier or health care plan; and

(ii) if applicable, the fact that the entity is managed, controlled, or operated by any health care provider or supplier or health care plan.

(D) COMPONENT OF ANOTHER ORGANIZATION.—If the entity is a component of another organization—

(i) the entity shall maintain Federal health care data and reports separately from the rest of the organization and establish appropriate security measures to maintain the confidentiality and privacy of the Federal health care data and reports; and

(ii) the entity shall not make an unauthorized disclosure to the rest of the organization of Federal health care data or reports in breach of such confidentiality and privacy requirement.

(E) TERMINATION OR NONRENEWAL.—If a contract under this section is terminated or not renewed, the following requirements shall apply:

(i) CONFIDENTIALITY AND PRIVACY PROTECTIONS.—The entity shall continue to comply with the confidentiality and privacy requirements under this section with respect to all Federal health care data disclosed to the entity and each report developed by the entity.

(ii) DISPOSITION OF DATA AND REPORTS.—The entity shall—

(I) return to the Secretary all Federal health care data disclosed to the entity and each report developed by the entity; or

(II) if returning the Federal health care data and reports is not practicable, destroy the reports and Federal health care data.

(4) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Federal Procurement Policy Act) shall be used to enter into contracts under paragraph (1).

(5) REVIEW OF CONTRACT IN THE EVENT OF A MERGER OR ACQUISITION.—The Secretary shall review the contract with a Quality Reporting Organization under this section in the event of a merger or acquisition of the Organization in order to ensure that the requirements under this section will continue to be met.

(e) DEVELOPMENT AND RELEASE OF REPORTS BASED ON REQUESTS.—

(1) REQUEST FOR A REPORT.—

(A) REQUEST.—

(i) IN GENERAL.—The procedures established under subsection (b)(1) shall include a process for an entity to submit a request to a Quality Reporting Organization for a report based on Federal health care data and private data that is publicly available or is provided by the entity making the request for the report. Such request shall comply with the purpose described in subsection (a).

(ii) REQUEST FOR SPECIFIC METHODOLOGY.—The process described in clause (i) shall permit an entity making a request for a report to request that a specific methodology, including appropriate risk adjustment, be used by the Quality Reporting Organization in developing the report. The Organization shall work with the entity making the request to finalize the methodology to be used.

(iii) REQUEST FOR A SPECIFIC QRO.—The process described in clause (i) shall permit an entity to submit the request for a report to any Quality Reporting Organization.

(B) RELEASE TO PUBLIC.—The procedures established under subsection (b)(1) shall provide that at the time a request for a report is finalized under subparagraph (A) by a Quality Reporting Organization, the Organization shall make available to the public, through the Internet website of the Department of Health and Human Services and other appropriate means, a brief description of both the requested report and the methodology to be used to develop such report.

(2) DEVELOPMENT AND RELEASE OF REPORT.—

(A) DEVELOPMENT.—

(i) IN GENERAL.—If the request for a report complies with the purpose described in subsection (a), the Quality Reporting Organization may develop the report based on the request.

(ii) REQUIREMENT.—A report developed under clause (i) shall include a detailed description of the standards, methodologies, and measures of quality used in developing the report.

(B) REVIEW OF REPORT BY SECRETARY TO ENSURE COMPLIANCE WITH PRIVACY REQUIREMENT.—Prior to a Quality Reporting Organization releasing a report under subparagraph (C), the Secretary shall review the report to ensure that the report complies with the Federal regulations (concerning the privacy of individually identifiable beneficiary health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable beneficiary health information. The Secretary shall act within 30 business days of receiving such report.

(C) RELEASE OF REPORT.—

(i) RELEASE TO ENTITY MAKING REQUEST.—If the Secretary finds that the report complies with the provisions described in subparagraph (B), the Quality Reporting Organization shall release the report to the entity that made the request for the report.

(ii) RELEASE TO PUBLIC.—The procedures established under subsection (b)(1) shall provide for the following:

(I) UPDATED DESCRIPTION.—At the time of the release of a report by a Quality Reporting Organization under clause (i), the entity shall make available to the public, through the Internet website of

the Department of Health and Human Services and other appropriate means, an updated brief description of both the requested report and the methodology used to develop such report.

(II) COMPLETE REPORT.—Not later than 1 year after the date of the release of a report under clause (i), the report shall be made available to the public through the Internet website of the Department of Health and Human Services and other appropriate means.

(f) ANNUAL REVIEW OF REPORTS AND TERMINATION OF CONTRACTS.—

(1) ANNUAL REVIEW OF REPORTS.—The Comptroller General of the United States shall review reports released under subsection (e)(2)(C) to ensure that such reports comply with the purpose described in subsection (a) and annually submit a report to the Secretary on such review.

(2) TERMINATION OF CONTRACTS.—The Secretary may terminate a contract with a Quality Reporting Organization if the Secretary determines that there is a pattern of reports being released by the Organization that do not comply with the purpose described in subsection (a).

(g) FEES.—

(1) FEES FOR SECRETARY.—The Secretary shall charge a Quality Reporting Organization a fee for—

(A) disclosing the data under subsection (c); and

(B) conducting the review under subsection (e)(2)(B).

The Secretary shall ensure that such fees are sufficient to cover the costs of the activities described in subparagraph (A) and (B).

(2) FEES FOR QRO.—

(A) IN GENERAL.—Subject to subparagraphs (A) and (B), a Quality Reporting Organization may charge an entity making a request for a report a reasonable fee for the development and release of the report.

(B) DISCOUNT FOR SMALL ENTITIES.—In the case of an entity making a request for a report (including a not-for-profit) that has annual revenue that does not exceed $10,000,000, the Quality Reporting Organization shall reduce the reasonable fee charged to such entity under subparagraph (A) by an amount equal to 10 percent of such fee.

(C) INCREASE FOR LARGE ENTITIES THAT DO NOT AGREE TO RELEASE REPORTS WITHIN 6 MONTHS.—In the case of an entity making a request for a report that is not described in subparagraph (B) and that does not agree to the report being released to the public under clause (ii)(II) of subsection (e)(2)(C) within 6 months of the date of the release of the report to the entity under clause (i) of such subsection, the Quality Reporting Organization shall increase the reasonable fee charged to such entity under subparagraph (A) by an amount equal to 10 percent of such fee.

(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed to effect the requirement that a report be released to the public under clause (ii)(II) of subsection

(e)(2)(C)(ii)(II) by not later than 1 year after the date of the release of the report to the requesting entity under clause (i) of such subsection.

(h) COORDINATION.—Not later than 1 year after the date of enactment of this title, the Secretary shall submit a report (including recommendations) to the appropriate committees of Congress concerning the coordination of existing Federal health care quality initiatives.

(i) REGULATIONS.—Not later than 6 months after the date of enactment of this section, the Secretary shall prescribe regulations to carry out this section.

SEC. 3007. RESEARCH ACCESS TO HEALTH CARE DATA AND REPORTING ON PERFORMANCE.

The Secretary shall permit researchers that meet criteria used to evaluate the appropriateness of the release data for research purpose (as established by the Secretary) to—

(1) have access to all Federal health care data (as defined in section 3006(b)(2)(A)); and

(2) report on the performance of health care providers and suppliers, including reporting in a provider- or supplier-identfiable format.

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SEC. 3008. FACILITATING THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.

(a) COMPETITIVE GRANTS FOR ADOPTION OF TECHNOLOGY.—

(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to facilitate the purchase and enhance the utilization of qualified health information technology systems to improve the quality and efficiency of health care.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(B) submit to the Secretary a strategic plan for the implementation of data sharing and interoperability measures;

(C) adopt the standards adopted by the Federal Government under section 3005;

(D) implement the measures adopted under section 3010 and report to the Secretary on such measures;

(E) agree to notify individuals if their individually identifiable health information is wrongfully disclosed;

(F) take into account the input of employees and staff who are directly involved in patient care of such health care providers in the design, implementation, and use of qualified health information technology systems;

(G) demonstrate significant financial need;

(H) provide matching funds in accordance with paragraph (4); and

(I) be a—

(i) public or not for profit hospital;

(ii) federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act);

(iii) individual or group practice (or a consortium thereof); or

(iv) another health care provider not described in clause (i) or (ii);

that serves medically underserved communities.

(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to—

(A) facilitate the purchase of qualified health information technology systems;

(B) train personnel in the use of such systems;

(C) enhance the utilization of qualified health information technology systems (which may include activities to increase the awareness among consumers of health care privacy protections); or

(D) improve the prevention and management of chronic disease.

(4) MATCHING REQUIREMENT.—To be eligible for a grant under this subsection an entity shall contribute non-Federal contributions to the costs of carrying out the activities for which the grant is awarded in an amount equal to $1 for each $3 of Federal funds provided under the grant.

(5) PREFERENCE IN AWARDING GRANTS.—In awarding grants under this subsection the Secretary shall give preference to—

(A) eligible entities that will improve the degree to which such entity will link the qualified health information system to local or regional health information plan or plans; and

(B) with respect to awards made for the purpose of providing care in an outpatient medical setting, entities that organize their practices as a patient-centered medical home.

(b) COMPETITIVE GRANTS FOR THE DEVELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE THE WIDE-SPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

(1) IN GENERAL.—The Secretary may award competitive grants to States for the establishment of State programs for loans to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology.

(2) ESTABLISHMENT OF FUND.—To be eligible to receive a competitive grant under this subsection, a State shall establish a qualified health information technology loan fund (referred to in this subsection as a "State loan fund" and comply with the other requirements contained in this subsection. Amounts received under a grant under this subsection shall be deposited in the State loan fund established by the State. No funds authorized by other provisions of this title to be used for other purposes specified in this title shall be deposited in any such State loan fund.

(3) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) a State shall—

(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(B) submit to the Secretary a strategic plan in accordance with paragraph (4);

(C) establish a qualified health information technology loan fund in accordance with paragraph (2);

(D) require that health care providers receiving loans under the grant—

(i) link, to the extent practicable, the qualified health information system to a local or regional health information network;

(ii) consult, as needed, with the Health Information Technology Resource Center established in section 914(d) to access the knowledge and experience of existing initiatives regarding the successful implementation and effective use of health information technology;

(iii) agree to notify individuals if their individually identifiable health information is wrongfully disclosed; and

(iv) take into account the input of employees and staff who are directly involved in patient care of such health care providers in the design and implementation and use of qualified health information technology systems;

(E) require that health care providers receiving loans under the grant adopt the standards adopted by the Federal Government under section 3005;

(F) require that health care providers receiving loans under the grant implement the measures adopted under section 3010 and report to the Secretary on such measures; and

(G) provide matching funds in accordance with paragraph (8).

(4) STRATEGIC PLAN.—

(A) IN GENERAL.—A State that receives a grant under this subsection shall annually prepare a strategic plan that identifies the intended uses of amounts available to the State loan fund of the State.

(B) CONTENTS.—A strategic plan under subparagraph (A) shall include—

(i) a list of the projects to be assisted through the State loan fund in the first fiscal year that begins after the date on which the plan is submitted;

(ii) a description of the criteria and methods established for the distribution of funds from the State loan fund;

(iii) a description of the financial status of the State loan fund and the short-term and long-term goals of the State loan fund; and

(iv) a description of the strategies the State will use to address challenges in the adoption of health information technology due to limited broadband access.

(5) USE OF FUNDS.—

(A) IN GENERAL.—Amounts deposited in a State loan fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, or as a source of reserve and security for leveraged loans, the proceeds of which are deposited in the State loan fund established under paragraph (1). Loans

under this section may be used by a health care provider to—

(i) facilitate the purchase of qualified health information technology systems;

(ii) enhance the utilization of qualified health information technology systems (which may include activities to increase the awareness among consumers of health care of privacy protections and privacy rights); or

(iii) train personnel in the use of such systems.

(B) LIMITATION.—Amounts received by a State under this subsection may not be used—

(i) for the purchase or other acquisition of any health information technology system that is not a qualified health information technology system;

(ii) to conduct activities for which Federal funds are expended under this title, or the amendments made by the Wired for Health Care Quality Act; or

(iii) for any purpose other than making loans to eligible entities under this section.

(6) TYPES OF ASSISTANCE.—Except as otherwise limited by applicable State law, amounts deposited into a State loan fund under this subsection may only be used for the following:

(A) To award loans that comply with the following:

(i) The interest rate for each loan shall be less than or equal to the market interest rate.

(ii) The principal and interest payments on each loan shall commence not later than 1 year after the date on which the loan was awarded, and each loan shall be fully amortized not later than 10 years after such date.

(iii) The State loan fund shall be credited with all payments of principal and interest on each loan awarded from the fund.

(B) To guarantee, or purchase insurance for, a local obligation (all of the proceeds of which finance a project eligible for assistance under this subsection) if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

(C) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the State if the proceeds of the sale of the bonds will be deposited into the State loan fund.

(D) To earn interest on the amounts deposited into the State loan fund.

(7) ADMINISTRATION OF STATE LOAN FUNDS.—

(A) COMBINED FINANCIAL ADMINISTRATION.—A State may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with State law, the financial administration of a State loan fund established under this subsection with the financial administration of any other revolving fund established by the State if not otherwise prohibited by the law under which the State loan fund was established.

(B) COST OF ADMINISTERING FUND.—Each State may annually use not to exceed 4 percent of the funds provided to

the State under a grant under this subsection to pay the reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a State loan fund which are incurred after the date of enactment of this title.

(C) GUIDANCE AND REGULATIONS.—The Secretary shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this subsection, including—

(i) provisions to ensure that each State commits and expends funds allotted to the State under this subsection as efficiently as possible in accordance with this title and applicable State laws; and

(ii) guidance to prevent waste, fraud, and abuse.

(D) PRIVATE SECTOR CONTRIBUTIONS.—

(i) IN GENERAL.—A State loan fund established under this subsection may accept contributions from private sector entities, except that such entities may not specify the recipient or recipients of any loan issued under this subsection.

(ii) AVAILABILITY OF INFORMATION.—A State shall make publicly available the identity of, and amount contributed by, any private sector entity under clause (i) and may issue letters of commendation or make other awards (that have no financial value) to any such entity.

(8) MATCHING REQUIREMENTS.—

(A) IN GENERAL.—The Secretary may not make a grant under paragraph (1) to a State unless the State agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash toward the costs of the State program to be implemented under the grant in an amount equal to not less than $1 for each $1 of Federal funds provided under the grant.

(B) DETERMINATION OF AMOUNT OF NONFEDERAL CONTRIBUTION.—In determining the amount of non-Federal contributions that a State has provided pursuant to subparagraph (A), the Secretary may not include any amounts provided to the State by the Federal Government.

(9) PREFERENCE IN AWARDING GRANTS.—The Secretary may give a preference in awarding grants under this subsection to States that adopt value-based purchasing programs to improve health care quality.

(10) REPORTS.—The Secretary shall annually submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report summarizing the reports received by the Secretary from each State that receives a grant under this subsection.

(c) COMPETITIVE GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.—

(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to implement regional or local health information plans to improve health care quality and efficiency

through the electronic exchange of health information pursuant to the standards, implementation specifications and certification criteria, and other requirements adopted by the Secretary under section 3010.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

(A) demonstrate financial need to the Secretary;

(B) demonstrate that one of its principal missions or purposes is to use information technology to improve health care quality and efficiency;

(C) adopt bylaws, memoranda of understanding, or other charter documents that demonstrate that the governance structure and decisionmaking processes of such entity allow for participation on an ongoing basis by multiple stakeholders within a community, including—

(i) health care providers (including health care providers that provide services to low income and underserved populations);

(ii) pharmacists or pharmacies;

(iii) health plans;

(iv) health centers (as defined in section 330(b)) and federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) and rural health clinics (as defined in section 1861(aa) of the Social Security Act), if such centers or clinics are present in the community served by the entity;

(v) patient or consumer organzations;

(vi) organizations dedicated to improving the health of vulnerable populations;

(vii) employers;

(viii) State or local health departments; and

(ix) any other health care providers or other entities, as determined appropriate by the Secretary;

(D) demonstrate the participation, to the extent practicable, of stakeholders in the electronic exchange of health information within the local or regional plan pursuant to subparagraph (C);

(E) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation in the health information plan by all stakeholders;

(F) adopt the standards adopted by the Secretary under section 3005;

(G) require that health care providers receiving such grants—

(i) implement the measures adopted under section 3010 and report to the Secretary on such measures; and

(ii) take into account the input of employees and staff who are directly involved in patient care of such health care providers in the design, implementation, and use of health information technology systems;

(H) agree to notify individuals if their individually identifiable health information is wrongfully disclosed;

(I) facilitate the electronic exchange of health information within the local or regional area and among local and regional areas;

(J) prepare and submit to the Secretary an application in accordance with paragraph (3);

(K) agree to provide matching funds in accordance with paragraph (5); and

(L) reduce barriers to the implementation of health information technology by providers.

(3) APPLICATION.—

(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(B) REQUIRED INFORMATION.—At a minimum, an application submitted under this paragraph shall include—

(i) clearly identified short-term and long-term objectives of the regional or local health information plan;

(ii) a technology plan that complies with the standards, implementation specifications, and certification criteria adopted under section 3003(c)(6) and that includes a descriptive and reasoned estimate of costs of the hardware, software, training, and consulting services necessary to implement the regional or local health information plan;

(iii) a strategy that includes initiatives to improve health care quality and efficiency, including the use and reporting of health care quality measures adopted under section 3010;

(iv) a plan that describes provisions to encourage the implementation of the electronic exchange of health information by all health care providers participating in the health information plan;

(v) a plan to ensure the privacy and security of individually identifiable health information that is consistent with Federal and State law;

(vi) a governance plan that defines the manner in which the stakeholders shall jointly make policy and operational decisions on an ongoing basis;

(vii) a financial or business plan that describes—

(I) the sustainability of the plan;

(II) the financial costs and benefits of the plan; and

(III) the entities to which such costs and benefits will accrue;

(viii) a description of whether the State in which the entity resides has received a grant under section 319D, alone or as a part of a consortium, and if the State has received such a grant, how the entity will coordinate the activities funded under such section 319D with the system under this section; and

(ix) in the case of an applicant entity that is unable to demonstrate the participation of all stakeholders pursuant to paragraph (2)(C), the justification from the entity for any such nonparticipation.

(4) USE OF FUNDS.—Amounts received under a grant under paragraph (1) shall be used to establish and implement a regional or local health information plan in accordance with this subsection.

(5) MATCHING REQUIREMENT.—

(A) IN GENERAL.—The Secretary may not make a grant under this subsection to an entity unless the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the infrastructure program for which the grant was awarded, the entity will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount equal to not less than 50 percent of such costs ($1 for each $2 of Federal funds provided under the grant).

(B) DETERMINATIION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under subparagraph (A) may be in cash or in kind, fairly evaluated, including equipment, technology, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(d) REPORTS.—Not later than 1 year after the date on which the first grant is awarded under this section, and annually thereafter during the grant period, an entity that receives a grant under this section shall submit to the Secretary a report on the activities carried out under the grant involved. Each such report shall include—

(1) a description of the financial costs and benefits of the project involved and of the entities to which such costs and benefits accrue;

(2) an analysis of the impact of the project on health care quality and safety;

(3) a description of any reduction in duplicative or unnecessary care as a result of the project involved; and

(4) other information as required by the Secretary.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—For the purpose of carrying out this section, there is authorized to be appropriated $139,000,000 for fiscal year 2008 and $139,000,000 for fiscal year 2009.

(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available through fiscal year 2012.

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SEC. 3009. DEMONSTRATION PROGRAM TO INTEGRATE INFORMATION TECHNOLOGY INTO CLINICAL EDUCATION.

(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals or analyze clinical data sets to discover quality measures. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of nursing; or

(C) an institution with a graduate medical education program;

(3) provide for the collection of data regarding the effectiveness of the demonstration project to be funded under the grant in improving the safety of patients and the efficiency of health care delivery; and

(4) provide matching funds in accordance with subsection (d).

(c) USE OF FUNDS.—

(1) IN GENERAL.—With respect to a grant under subsection (a), an eligible entity or consortium shall use amounts received under the grant in collaboration with 2 or more disciplines.

(2) LIMITATION.—An eligible entity or consortium shall not award a grant under subsection (a) to purchase hardware, software, or services.

(d) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity under or consortium this section only if the entity of consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $2 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(e) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(f) REPORTS.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects established under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (e).

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $2,000,000 for each of fiscal years 2008 and 2009.

(h) SUNSET.—This provisions of this section shall not apply after September 30, 2012.

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SEC. 3010. FOSTERING DEVELOPMENT AND USE OF HEALTH CARE QUALITY MEASURES.

(a) IN GENERAL.—The Secretary shall provide for the development and use of health care quality measures (referred to in this title as "quality measures") for the purpose of measuring the quality and efficiency of health care that patients receive.

(b) DESIGNATION OF, AND ARRANGEMENT WITH, ORGANIZATION.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this title, the Secretary shall designate, and have in effect an arrangement with, a single organization that meets the requirements of subsection (c) under which such organization shall promote the development of quality measures and provide the Secretary with advice and recommendations on the key elements and priorities of a national system for healthcare performance measurement.

(2) RESPONSIBILITIES.—The responsibilities to be performed by the organization designated under paragraph (1) (in this title referred to as the "designated Organization") shall include—

(A) establishing and managing an integrated national strategy and process for setting priorities and goals in establishing quality measures;

(B) coordinating and harmonizing the development and testing of such measures;

(C) establishing standards for the development and testing of such measures;

(D) endorsing national consensus quality measures;

(E) recommending, in collaboration with multi-stakeholder groups, quality measures to the Secretary for adoption and use;

(F) promoting the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information; and

(G) providing recommendations and advice to the Partnership regarding the integration of quality measures into the certification process outlined under section 3003 and the Community regarding national policies outlined under section 3004.

(c) REQUIREMENTS DESCRIBED.—The requirements described in this subsection are the following:

(1) PRIVATE ENTITY.—The organization shall be a private nonprofit entity that is governed by a board of directors and an individual who is designated as president and chief executive officer.

(2) BOARD MEMBERSHIP.—The members of the board of directors of the entity shall include representatives of—

(A) health care providers or groups representing providers;

(B) health plans or groups representing health plans;

(C) patients or consumers enrolled in such plans or groups representing individuals enrolled in such plans;

(D) health care purchasers and employers or groups representing purchasers or employers; and

(E) organizations that develop health information technology standards and new health information technology.

(3) OTHER MEMBERSHIP REQUIREMENTS.—The membership of the board of directors of the entity shall be representative of individuals with experience with—

(A) urban health care issues;

(B) safety net health care issues;

(C) rural or frontier health care issues;

(D) quality and safety issues;

(E) State or local health programs;

(F) individuals or entities skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment; and

(G) individuals or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.

(4) OPEN AND TRANSPARENT.—With respect to matters related to the arrangement with the Secretary under subsection (a)(l), the organization shall conduct its business in an open and transparent manner, and provide the opportunity for public comment and ensure a balance among disparate stakeholders, so that no member organization unduly influences the work of the organization.

(5) VOLUNTARY CONSENSUS STANDARDS SETTING ORGANIZATIONS.—The organization shall operate as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

(6) PARTICIPATION.—If the organization requires a fee for membership, the organization shall ensure that such fee is not a substantial barrier to participation in the entity's activities related to the arrangement with the Secretary.

(d) REQUIREMENTS FOR MEASURES.—The quality measures developed under this title shall comply with the following:

(1) MEASURES.—The designated organization, in promoting the development of quality measures under this title, shall ensure that such measures—

(A) are evidence-based, reliable, and valid;

(B) include—

(i) measures of clinical processes and outcomes, patient experience, efficiency, and equity; and

(ii) measures to assess effectiveness, timeliness, patient self-management, patient centeredness, and safety; and

(C) include measures of underuse and overuse.

(2) PRIORITIES.—In carrying out its responsibilities under this section, the designated organization shall ensure that priority is given to—

(A) measures with the greatest potential impact for improving the performance and efficiency of care;

(B) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hos-

pitals, nursing homes, long-term care providers, and other providers;

(C) measures which may inform health care decisions made by consumers and patients;

(D) measures that apply to multiple services furnished by different providers during an episode of care;

(E) measures that can be integrated into certification process described in section 3003; and

(F) measures that may be integrated into the decision support function of qualified health information technology as defined by this title.

(3) RISK ADJUSTMENT.—The designated organization, in consultation with performance measure developers and other stakeholders, shall establish procedures to ensure that quality measures take into account differences in patient health status, patient characteristics, and geographic location, as appropriate.

(4) MAINTENANCE.—The designated organization, in consultation with owners and developers of quality measures, shall require the owners or developers of quality measures to update and enhance such measures, including the development of more accurate and precise specifications, and retire existing out-dated measures. Such updating shall occur not more often than once during each 12-month period, except in the case of emergency circumstances requiring a more immediate update to a measure.

(e) GRANTS FOR PERFORMANCE MEASURE DEVELOPMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, may award grants, in amounts not to exceed $50,000 each, to organizations to support the development and testing of quality measures that meet the standards established by the designated organization.

SEC. 3011. ADOPTION AND USE OF QUALITY MEASURES; REPORTING.

(a) IN GENERAL.—For purposes of carrying out activities authorized or required by this title to ensure the use of quality measures and to foster uniformity between health care quality measures utilized by private entities, the Secretary shall—

(1) select quality measures for adoption and use, from quality measures recommended by multi-stakeholder groups and endorsed by the designated organization; and

(2) ensure that standards adopted under section 3005 integrate the quality measures endorsed, adopted, and utilized under this section.

(b) RELATIONSHIP WITH PROGRAMS UNDER THE SOCIAL SECURITY ACT.—The Secretary shall ensure that the quality measures adopted under this section—

(1) complement quality measures developed by the Secretary under programs administered by the Secretary under the Social Security Act, including programs under titles XVIII, XIX, and XXI of such Act; and

(2) do not conflict with the needs and priorities of the programs under titles XVIII, XIX, and XXI of such Act, as set forth by the Administrator of the Centers for Medicare & Medicaid Services.

(c) REPORTING.— The Secretary shall implement procedures, consistent with generally accepted standards, to enable the Department

of Health and Human Services to accept the electronic submission of data for purposes of performance measurement, including at the provider level, using the quality measures developed, endorsed, and adopted pursuant to this title.

(d) DISSEMINATION OF INFORMATION.—In order to make comparative performance information available to health care consumers, health professionals, public health officials, oversight organizations, researchers, and other appropriate individuals and entities, after consultation with multi-stakeholder groups, the Secretary shall promulgate regulations to provide for the dissemination, aggregation, and analysis of quality measures collected pursuant to this title.

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SEC. 3013. ENSURING PRIVACY AND SECURITY.

(a) PRIVACY PROTECTIONS APPLY TO HEALTH INFORMATION ELECTRONIC DATABASES.—An operator of a health information electronic database shall be deemed to be a "covered entity" for purposes of sections 1171 through 1179 of the Social Security Act and the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) (referred to in this section as the "HIPAA privacy regulations").

(b) HEALTH INFORMATION ELECTRONIC DATABASE DEFINED.—In this section, the term "operator of a health information electronic database" means an entity that—

(1) is constituted, organized, or chartered for the primary purpose of maintaining or transmitting protected health information in a designated record set or sets;

(2) receives valuable consideration for maintaining or transmitting protected health information in a designated record set or sets; and

(3) is not a health plan, healthcare clearinghouse, or healthcare provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1) of the Social Security Act.

(c) RIGHT OF INDIVIDUALS TO INSPECT THEIR MEDICAL RECORDS MAINTAINED IN ELECTRONIC FORMAT.—To the extent provided for under the HIPAA privacy regulations with respect to protected health information, an individual shall have a right of access to inspect and obtain a copy of protected health information about the individual stored in electronic format.

(d) RIGHTS OF INDIVIDUALS WHO ARE VICTIMS OF MEDICAL FRAUD.—To the extent provided for under the HIPAA privacy regulations and under the conditions specified in such regulations, with respect to protected health information, an individual who is a victim of medical fraud or who believes that there is an error in their protected health information stored in an electronic format shall have the right—

(1) to have access to inspect and obtain a copy of protected health information about the individual, including the information fraudulently entered, in a designated record set; and

(2) to have a covered entity amend protected health information or a record about the individual, including information fraudulently entered, in a designated electronic record set for as long as the protected health information is maintained in the

designated electronic record set to ensure that fraudulent and inaccurate health information is not shared or re-reported.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to supercede or otherwise limit the provisions of any contract that provides for the application of privacy protections that are greater than the privacy protections provided for under the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.

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